JUST FOR KIDS PEDIATRIC DENTISTRY, LTD

Patient Information

Child's Name______________________________AGE________Date of Birth________________

Parent's Names____

Address_____________________________________City__________________Zip_____________

Marital Status (M)___(S)___(D)____ With Whom do children reside?_______________________

Telephone: Residence____________________Father Work/Cell______________________________

E-Mail ________________________________Mother Work/Cell_____________________________

With Whom may we discuss child's treatment? Check all that apply, AND <u>SIGN BELOW</u>…

Parent(s)__________Custodial parent only____________Childcare person_____ _______________

Other/Family Friend____________________________Name Relationship to patient_____________

SIGNATURE______________________________DATE________________

Father Employed by____How Long_________________

Mother Employed by____How Long_________________

<u>REFERRED BY</u> (*or how your heard about our office*)____

Dental Insurance: If you have Dental insurance please complete insurance information sheet.

<u>Social Security #</u>:

Father______________________________ Mother______________________________

<u>Driver's License #</u>

Father_______________________________ Mother______________________________

Nearest Relative Name:___________________________Relationship to Patient_________________

Phone Number(s)____

Signature______________________________ **Date**_______________________________

Although we treat the area in and around your mouth, your child's mouth is a part of their entire body. Health problems or medication the patient may be taking could have an important interrelationship with the dentistry they will receive. (original)

Child's Name______________________________________ **Birth Date**:_____________________**Date Created**:________________

DENTAL HISTORY

Reason for bringing your child to dentist?____

Has your child ever been to the dentist? YES_______ NO_________ If Yes, Date of last visit?____________________________

If yes, how was your child's past dental experience? **Positive/Negative** Comments______________________________________

Anything you feel we should know about your child?____

Has your child ever experienced an adverse reaction during, or in conjunction with a medical or dental procedure?

_____YES ______NO Please explain____

How often does the patient brush?______________________Floss?____________________Do you assist?_________

Circle *EACH* Y or N Has you child had or have any of the following:

Y/N Bad Breath	Y/N Sensitivity to hot/cold	Y/N Loose teeth or broken fillings
Y/N Bleeding gums	Y/N Sensitivity when biting	Y/N Food collection between teeth
Y/N Grinding or clenching teeth	Y/N Sensitivity to sweets	Y/N Sores or growth in mouth
Y/N Clicking or popping jaw	Y/N Finger, thumb or pacifier habit PAST OR PRESENT	Y/N Fluoride supplements

MEDICAL HISTORY

Name of child's physician____Phone #____________________________

Date of Last visit________________________________ Child's Immunizations up to date? _______YES ________NO

Does your child see a Specialist? **Y/N** If Yes, Reason?____

Is your child presently under medical care? **Y/N** Please Explain:____

Is your child currently taking medications? **Y/N** If yes, Reason ____

List of Medications:____

Has your child ever been hospitalized or put to sleep for an operation? **Y/N** If yes, please list procedures and dates :

____

Has child's physician ever recommended antibiotics for dental treatment? **Y/ N** If yes REASON:_________________________

Is your child allergic to any of the following? Circle ones that apply:_________________________

Penicillin Gluten Food Dye Sulfa Drugs Local Anesthetics Latex Dairy Peanuts Tree Nuts Seasonal

OTHER?____

PLEASE CIRCLE *EACH* Y or N if you child has had any of the following:

Y/N Heart Disease	Y/N Abnormal Bleeding from cut	Y/N Asthma/Breathing problems
Y/N Heart Murmur	Y/N Unexplained Bruising	Y/N Diabetes
Y/N Congenital Heart Defect	Y/N Frequent Nose Bleeds	Y/N Seizures/Epilepsy
Y/N Rheumatic Fever	Y/N Hemophilia/Bleeding disorder	Y/N Hepatitis
Y/N Mononucleosis	Y/N Anemia	Y/N HIV or AIDS
Y/N Bone problems	Y/N Blood transfusions	Y/N Cancer

If yes to ANY Please explain:____

Any other Medical Conditions:____

Mental Development: _______Normal _______1-2 years behind ____ More than 2 years behind

Patient Diagnosed with: Autism **Y/N** Aspergers **Y/N** ADHD **Y/N** Anxiety **Y/N** Depression**Y/N** Sensory issues **Y/N**

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform office of any changes in my child's medical condition.

Sign: ____**Date:**____________________________________

Sign Review:____**Date:**___________________________________

Sign RevIew:____**Date**:___________________________________

Thank You

JUST FOR KIDS

Insurance Information* We are considered **"out of network"** with all insurance companies, however we are in contract with Delta Dental Premier and United Concordia/Comcast

Patient Last Name_____________________First Name________________________

Parents Names______________________________Marital Status M D S W

Home Address____

Phone Number_______________Cell/Home Alternate#________________Cell/Home

Date of Birth___________________ Sex M F

PRIMARY DENTAL INSURANCE

Subscriber full name______________________________________ SEX M F

Relationship to Patient_______________SS#____________________DOB:__________

Employer Name______________________________ Group #______________________

Member ID number________________________________

Insurance Company Name____

Address of Ins Co.____

SECONDARY DENTAL COVERAGE

Subscriber full name______________________________________ SEX M F

Relationship to Patient_______________SS#____________________DOB:__________

Employer Name______________________________ Group #______________________

Insurance Company Name____

Address of Ins Co.____

Parent Guardian Responsible for patient

PRINT NAME____

Signature____DATE____________________

JUST FOR KIDS PEDIATRIC DENTISTRY, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment**

I have received a copy of this office's Notice of Privacy Practices.

Print Parent/Guardian Name:____

Print child(ren)'s Name:____

Signature:____

Date:________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Just For Kids Pediatric Dentistry

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2019 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;

- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Cami Anderson

Telephone: 630-961-0996 **Fax:** 630-579-0850

Address: 1220 Hobson Rd, Suite 224, Naperville, IL 60540

E-mail: Cami.Anderson@justforkidsnaperville.com

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Welcome to Just for Kids Pediatric Dentistry, Ltd.!

Consent for dental examinations for ____.

Thank you for choosing us as your child's dentist. We are committed to your child's successful treatment. Please understand that prompt payment of the account is considered a part of your child's treatment. The following is a statement of our policies.

OFFICE VISITS

Payment for the initial examination is due at the time of service. Payment for all other visits is due at the time of service unless prior arrangements have been made (see Financial policy & Insurance below).

All children will be brought back to visit with the dentist by themselves. Only for extremely young patients or for patients with special needs will an exception be made to this policy. A parent or legal guardian MUST be present for all appointments.

The initial visit is spent conducting a thorough examination. We need to know important medical facts about your child and ask that you complete the medical history as accurately as possible. Depending on your child's age, several x-rays will be taken to determine the presence of cavities between the teeth and the number and location of permanent teeth. We will examine, clean and apply flouride to the teeth. We will then discuss the findings with you. **The doctors assess cavity risk and recommend x-rays and fluoride based on what is best for our patients, regardless of whether your insurance covers this or not.** We do our best to limit out of pocket expenses, but it is ultimately up to you the parent to inform our team if you do NOT wish to have certain services rendered because of insurance reasons.

Recall (6 month) examinations will be conducted in a similar manner. However, if your child maintains zero cavity growth for one full year, we will recommend that diagnostic x-rays be taken on an annual basis rather than at each six-month recall appointment. **IT IS IMPERATIVE THAT ALL CHANGES TO YOUR CHILD'S MEDICAL HISTORY BE BROUGHT TO OUR ATTENTION BEFORE YOUR CHILD IS TAKEN BACK TO SEE THE DENTIST**. **INITIAL**____________________

FINANCIAL POLICY & INSURANCE:

We are "out of network" with insurance companies. However, we are in contract with Delta Dental Premier & United Concordia/Comcast Employer. Your insurance coverage is a contract between you and your insurance company. Since we are not a party to that contract, we ask that you keep in contact with your insurance company to check status of outstanding claims. **If your insurance company does not make payments to out-of-network providers, payment is due at the time of services. If you do NOT have dental insurance, payment is due at the time of service.** We may accept assignment of insurance benefits; however, we will require 30-50% payment of all restorative charges to be paid at time of services. Any balance automatically becomes your responsibility and must be paid in full within 14 days of the appointment date. **IF THERE ARE ANY CHANGES TO THE INSURANCE INFORMATION, WE HAVE ON FILE, LET US KNOW WHEN YOU ARE CHECKING YOUR CHILD IN.** Please ask our team about CARE CREDIT as a payment option.

INITIAL____________________

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MISSED APPOINTMENTS:

You must provide at least 24 hours' notice if you cancel/miss your schedule appointment. Otherwise we reserve the right to charge an amount of $50.00 for a broken appointment. If three appointments are missed during peak, non-school hours, we reserve the right to schedule appointments for your child only during non-peak hours. **INITIAL**_____________________

MONTHLY BILLING CHARGE:

If any portion of your account remains unpaid, a monthly billing charge of $1.50 per month will be added to the account after 45 days ***with no exceptions***.

OTHER CHARGES (Subject to change without notice)

Duplication of Records: $15.00 per child
Returned Check: $35.00

Thank you for reading and understanding our office policies. Please let us know if you have any questions or concerns.
I have read the above information and understand and agree to the contents of this document. Your signature on this document gives permission for insurance benefits to be assigned to the dentist.

______________________________________ ___________________________

SIGNATURE RELATIONSHIP TO CHILD

____

DATE

2019